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DEPARTMENT OF MENTAL HEALTH
Patients' Rights Office
550 S. Vermont Ave., 6th Floor
Los Angeles, CA 90020

LETTER RESPONDING TO CLIENT'S REQUEST FOR ACCESS TO HEALTH INFORMATION

{Mr./Ms./Mrs. Client's Name}
{Client's Address}
{City, State Zip Code}

Date of Birth: {Date}
Client ID #: _____

{Date of Letter}

Dear {Mr./Ms./Mrs. Client's Name}:

Thank you for submitting your ***Request for Access to Health Information***. Your request was forwarded to the responsible practitioner for review.

We received your written request, stamped on mm/dd/yyyy , to access your protected health information. We have determined that:

☐ Your request has been accepted, and the information is included with this notice. The cost for this service is $, based on a charge of 25 cents per page, and a bill will be sent to your home of record.

☐ Your request has been accepted, and the following appointment time has been scheduled for your records review:

Date: {Date}
Time: {Time}
Location: {Facility Address}

If you have any questions or need to reschedule, please contact the Treatment Team or call us at {Facility Phone No.}

☐ We will grant your request to access, but only in part (see below regarding the reason for partial denial). We will provide access to the following health information:

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REASON FOR DENIAL (IF APPLICABLE)

Your request to access your protected health information is denied because:

- ☐ You are not authorized access to the health information.
- ☐ We are not permitted to release health information regarding information compiled in anticipation of or use in a civil, criminal, or administrative action or proceeding. **This denial is not subject to the right to review.**
- ☐ You did not provide all the information we need to complete your request. Please complete the highlighted items identified and return it to us.
- ☐ You were unable to provide satisfactory personal identification to access your own information.
- ☐ You were unable to provide satisfactory personal identification as proof of status as a patient's representative (parent, guardian or conservator).
- ☐ Other:

If we denied your request to access, you have the right to require LACDMH to permit inspection by, or provide copies to, a licensed mental health professional designated by you with your written authorization. If you want to exercise this right, please contact your Treatment Team.

REQUEST FOR REVIEW OF DENIAL OF ACCESS (IF APPLICABLE)

If we denied your request to access your protected health information, in whole or in part, you may submit a ***Request for Review of Denial of Access***, included with this letter. After completing the form, return it to the Treatment Team or mail it to:

Patients' Rights Office
Los Angeles County Department of Mental Health
550 S. Vermont Ave., 6th Floor
Los Angeles, CA 90020

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You also have the option to complain to either the County's Privacy Official or to the federal government. To file a complaint with Los Angeles County, contact:

HIPAA Compliance Unit
Los Angeles County Auditor-Controller
500 West Temple Street, Suite 515
Los Angeles, CA 90012
(213) 974-2164
Email: HIPPA@auditor.lacounty.gov

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

{Name}
Program / Unit Manager
Department of Mental Health
Los Angeles County